STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	44E200	A. BUILDING 01 - MAIN BUILDING 01 B. WING	08/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURELBROOK SANITARIUM	114 CAMPUS DRIVE DAYTON, TN 37321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on observation, record review and interview the facility failed to maintain smoke detectors. The finding includes: Observation, record review and interview on 8/23/16 at 2:40 PM revealed smoke detector sensitivity has not been conducted in the past two years. NFPA 72, 7-3.2.1 This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on 8/23/16.	K 054	1. On 8/31/16 received letter from Vendor stating that Fire Alarm Control Panel has built in monitoring system for smoke detectors and will trouble when they are out of range. 1. On 8/25/16 Maintenance installed FDC sign outside administrator's office and cleaned and lubricated couplings so they rotate freely. Vendor for sprinkler system verified that gauges were changed on 12/1/15 and 4/2/14 **(Exhibit #14)**. 2. On 8/25/16 Maintenance director verified that no other FDC connections were found. 3. On 8/25/16 Maintenance director posted date of last 5 years gauges replacement on board in maintenance department and placed within electronic maintenance program.	9/21/16
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the automatic sprinkler system: The findings include: Observation and interview with the maintenance director on 8/23/16 between 9:15 and 9:30 AM revealed; 1. The fire department connection outside the	K 062		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Keith Wells — TITLE: Administrator — (X6) DATE: 9/8/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 062	Continued From page 1 administrator's office did not have signage, and the couplings did not rotate freely. 2. There was no documentation confirming the 5 year gauge replacement/calibration had been done. NFPA 25, 10-2.2, 25, 9-7.1 These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on 8/23/16.	K 062	4 On 8/31/16 QA Director place alert box on QA meeting agenda for all QA members to see at each monthly meeting. The administrator will report problems to the Board of Directors.	9/21/16
K 063 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have an adequate and reliable water supply which provides continuous and automatic pressure. 9.7.1.1, NFPA 13 This STANDARD is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure automatic sprinkler system had an adequate and reliable water supply. The finding includes: Observation, record review and interview with the maintenance director on 8/23/16 revealed the fire pump annual performance test indicated "could not pump more than 68% due to low suction" resulting in a failed test. This percentage is a decrease from prior pump performance test. This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on 8/23/16.	K 063	1. On 8/25/16-9/9/16 Vendor was notified of fire pump performance and reviewed options and have attached letter (**Exhibit #15**) regarding plans to retest pump on 9/13/16. 2. No other fire pumps are located at this site. 3. If test fails again then Vendor will contract with pump company to repair and clean pump followed by a recheck with a new test. 4. Beginning on 9/9/16 all pump tests conducted since the last meeting will be brought to QA monthly along with the previous test by the Maintenance Director for review. The administrator will report findings to the Board of Directors.	
K 069 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96	K 069		

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K 069	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure dietary staff were familiar with hood suppression operation and the class K extinguisher had proper signage. The findings include: Observation and interview with the maintenance director on 8/23/16 between 9:30 and 10:00 AM revealed; 1. There was no signage above the class K extinguisher. 2. A dietary staff member was interviewed about the hood suppression system and was not familiar with how system operated. NFPA 96, 7-2.1 & NFPA 10, A.5.5.5.3 These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on 8/23/16.	K 069	1. On 8/24/16 signage was order for Class K fire extinguisher and will be installed by 9/13/16. Dietary Manager inserviced all kitchen staff on proper use of hood fire suppression system (**Exhibit #16**). 2. On 8/24/16 Dietary Manager inserviced 2nd shift staff on proper use of hood fire suppression system. 3. Starting 8/24/16 new staff will be oriented during their first week working in the kitchen and all staff will be inserviced and verbally quizzed each month while working in the kitchen. 4. Beginning on 9/1/16 QA Director will quiz kitchen staff at random monthly on proper use of kitchen fire suppression system (**Exhibit #17**) for 3 months then quarterly thereafter. QA will report findings monthly to the QA committee and the administrator will report findings to the Board of Directors.	9/21/16
K 130 SS=F	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain fire doors. The findings include: Observation and interview with the maintenance director on 8/23/16 between 9:45 and 11:51 AM revealed the facility failed to maintain fire doors. 1. The 90 minute fire door from the kitchen to dining room failed to close to a positive latch. 2. There were through holes in one of the	K 130		

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K 130	Continued From page 3 cross-corridor fire doors by the activities office. 3. The laundry room door by the cooler had the rating painted over. 4. The 90 minute medical records room fire door failed to close to a positive latch. NFPA 101, 8.2.3.2.1, NFPA 80, 15-2.5.3 These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on 8/23/16.	K 130	1. On 8/31/16 the Maintenance Director fixed the latching mechanism on the kitchen door and medical records door. The holes in the cross-corridor fire doors by activities room plugged with approved hardware. The Maintenance Director cleaned the laundry room door near cooler of paint on the rating sticker. 2. By 9/21/16 Maintenance Director will have checked all fire doors and all other doors that did not latch and have them repaired (**Exhibit #18**). 3. Beginning on 9/21/16 the Maintenance director will check all fire doors monthly for three (3) months for positive latching and then quarterly thereafter. 4. Beginning on 9/21/16 QA Director will randomly check 10 doors for positive latching and report findings to the QA committee. The administrator will report findings to the Board of Directors.	9/21/16